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### Bulletin - June, 1981

Civil Aviation Medical Association

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# CIVIL AVIATION MEDICAL ASSOCIATION

## BULLETIN

### JUNE 1981

(Headquarters)  
801 Green Bay Road  
Lake Bluff, Illinois 60044  
312/234-6330



#### The President's Message

By:  
**Halford R. Conwell, M.D.**

Halford R. Conwell, M.D.

The past several months have been busy ones for CAMA. We presented CAMA's position supportive of the Federal Air Surgeon's suggestion for minimal changes in the wording of cardiovascular standards. What was amazing was the amount of emotion that was generated by what seemed to be a relatively minor change.

More recently, Dr. Owen Coons of Dallas has been in Washington to present CAMA's views regarding far more profound changes recommended by the National Institute on Aging that could result in dramatic changes in the AME standards (see article in this issue).

A most agreeable contact was made in York, England, with the British Association of AME's. We represented CAMA at their most excellent symposium on the use of Beta Blockers. I can wholeheartedly recommend it to any of our members who have the opportunity to go to their meeting in Cambridge next year. It was one of the best, concise, scientific-clinical seminars that I have ever attended.

Our CAMA Luncheon in San Antonio seemed to be an unqualified success. Mr. Frank Rox, Senior Vice President of Delta Air Lines for Flight Operations, was gracious enough to fly from Atlanta the morning of our luncheon, deliver his remarks to a totally sold out and standing-room audience, and then return to Atlanta that afternoon.

There seems to be a genuine interest among the Executive Council of Aerospace for greater communi-

cation and cooperation with the Civil Aviation Medical Association. Their San Antonio meeting had one of the largest registrations that they have had in the past several years, and they have assured us that they are giving every consideration to any request we might make for their assistance in furthering our organization's aims.

Let me close by urging you to attend our October meeting in Hawaii. The prices appear reasonable, the program good, and we are fortunate enough to have that lovely Island of Kauai for our enjoyment, which is what people think Hawaii should be (both *South Pacific* and *Blue Hawaii* were filmed there).

We need your continued support to properly represent you in your important subspecialty of Aviation Medicine.



First Lady, Margaret Conwell, wife of Hal, in York England. On her right, the High Sheriff, on her left, the Lord Mayor.



# U.K. AVIATION MEDICAL EXAMINERS INAUGURAL SCIENTIFIC SESSION YORK, ENGLAND

By: Victor B. Maxwell, M.B., Ch.B.,  
M.R.C.G.P., Chairman, A.A.M.E.

The first scientific meeting of the Association of Aviation Medical Examiners was held in York, England on April 11th. The AAME was formed as a result of a meeting in 1980 of many authorised medical examiners, who felt that some form of professional body was necessary to represent their interests and, in particular, to provide a forum for the exchange and discussion of ideas relevant to their aviation duties. It was fitting that the theme chosen for this meeting was the place of beta adrenergic blocking agents in the treatment of mild to moderate hypertension in aircrew as the Civil Aviation Authority of the U.K. only recently approved three such agents (atenolol, acebutolol and metoprolol) for use in aircrew.

Dr. H.R. Conwell, President of CAMA, was among the delegates who listened to a valuable and varied scientific session chaired by Air Vice Marshall John Cooke, Dean of Air Force Medicine.

Following a brief review of the historical background to the introduction of beta blockade into aviation medicine, by Dr. P. Chapman, British Caledonian Airways Ltd., the current clinical and pharmacological thinking on these drugs was reviewed by Professor Sleight of Oxford and Professor Prichard of London both of whom had carried out pioneering work in this field. Wing Commander D.H. Glaister of the RAF Institute of Aviation Medicine presented a review of the literature covering possible psychomotor effects of beta blockade. Performance could be influenced either centrally by certain beta blockers penetrating the blood/brain barrier, or peripherally as in the well known effect of beta blockade on fine finger tremor. The former possibility, as examined by many of the participants, depended to large extent

## Association of Aviation Medical Examiners

### Registration



on the degree of lipid solubility of the beta-blocker—the less lipophilic, the less likely to penetrate the brain tissue. This was well illustrated by the valuable data on visual reaction time and miscellaneous central effects presented by Drs. D. Harms and E. Schenk of the German Institute of Aviation Medicine, who showed that reaction time was actually shortened and concentration ability improved in subjects who had taken atenolol, compared with placebo. Further relevant work, on driving skills and on kinetic visual acuity, formed the basis of the paper by a Consultant Psychiatrist, Dr. T. Betts of Birmingham, confirming the lack of central effects with atenolol. Mr. G. Neil Dwyer, a Consultant Neurosurgeon, who has been measuring the plasma/brain levels of various agents in patients who had suffered subarachnoid haemorrhage confirmed that water soluble beta blockers appeared in only very low concentrations in the brain, compared with lipid soluble drugs like propranolol. This may explain the difference in effect of these drugs on CNS.

During the concluding Panel discussion it became clear that the participants were unanimous that beta blocking agents could be safely prescribed. There seemed to be every reason for wanting to control the blood pressure of air crew. It appears likely this can now be done safely and without the limitation of troublesome or adverse side effects, the Panel were happy to see beta blockers being introduced into regular clinical use in aircrew where indicated by the clinical assessment.



LEFT TO RIGHT:  
Dr. D. Harms, Mr. G.  
Neil Dwyer, Dr. T.A.  
Betts, Wing-Commander  
D.H. Glaister, Professor  
B.N. Prichard.



# LETTER TO THE EDITOR



Health and Welfare  
Canada

Santé et Bien-être social  
Canada

Civil Aviation Medicine  
Place de Ville, Tower "C"  
Ottawa, Ontario.  
K1A 0N8

Editor  
Bulletin  
Civil Aviation Medical Association  
801 Green Bay Road  
Lake Bluff, Illinois 60044

Dear Sir:

I would like to commend you and your staff on the vastly improved format and content of the latest Bulletin.

Dr. Steven Mintz's article on the wearing of contact lenses, in general is explicit and lucid but what a difference one misquoted word can make. Had he quoted correctly "hard contact lens wearers 'may' instead of 'will' be required to carry two pairs of spectacle lenses", he could have avoided his plea that these people should not be penalized. Indeed, in the Canadian experience, few have been so "penalized".

I am sure that Ophthalmologists will wish to take issue with him on the subject of orthokeratology. Orthokeratology has been studied by leading International Ophthalmologists in the aviation field and like the use of the X-chrome lens as a method of correcting colour vision errors, both techniques are of such a temporary nature, neither is permitted by ICAO.

Orthokeratology is physiologically unsound, unproven, unpredictable and hazardous, and yet is frequently undertaken for purely cosmetic reasons. Little is known of the stress caused to the cornea affecting the blood supply by a series of contact lenses bending the inside of the cornea and thereby distorting the endothelium. Since the cornea does not remain molded, it is subjected to repeated insults, making it unable to dehydrate, and in addition, can create astigmatism and permanent changes.

Rather than be accused of further provoking the animosity existing between Optometrists and Ophthalmologists, I would invoke Dr. Mintz to refer to an Evaluation of Orthokeratology appearing in the American Academy of Ophthalmology pages 729-744, 1980, written jointly by Perry S. Binder, M.D., FACS; Charles H. May, O.D. and Stuart C. Grant, O.D.

Yours sincerely,

Roy M. Stewart, M. D.  
Consultant  
Civil Aviation Medicine



# XVI CAMA ANNUAL MEDICAL SYMPOSIUM PRELIMINARY SCIENTIFIC PROGRAM

**Thursday, October 8, 1981**

8:30 AM Aeromedical Indoctrination Programs  
In Mexico.  
Luis A. Amezcua G., M.D., Director,  
Centro Nacional de Medicina de  
Aviacion, D.G.A.C., Mexico.

9:30 AM Panel Session on "Airline Medical Crite-  
ria for Selection of Air Crew Members"  
Moderator:  
Peter Chapman, M.D., Medical  
Director of British Caledonian  
Airways  
Panel Members:  
Richard Harper, M.D.,  
United Air Lines.  
E. Lafontaine, M.D., Air France  
Earl T. Carter, M.D., Mayo Clinic

10:00 AM BREAK

10:30 AM Advances in Diagnosis and Prognosis  
of the Coronary Heart Diseases.  
Earl F. Beard, M.D., Houston, TX.

11:00 AM U.K. Medical Advisory Panel Recom-  
mendations on Cardiovascular Fit-  
ness of Airline Pilots.  
Geoffrey Bennett, M.D., Chief, Medi-  
cal Office, CAA, London, England.

12:00 PM LUNCH

14:30 PM Panel Session on "Common Problems  
in Aeromedical Certification"  
Moderator:  
Luis A. Amezcua G., M.D.  
Panel Members:  
Homer L. Reighard, M.D., FAA  
Robert Dille, M.D., FAA  
Geoffrey Bennett, M.D., CAA  
Elias Jacob H., M.D., Chile  
David Ibeas G., M.D., Argentina

15:30 PM BREAK

16:00 PM A Routine Procedure for Psychological  
Evaluation of Air Personnel, at AME's  
level.  
Carlos Palafox G., M.D., CENMA,  
Mexico.



Dr. Criss Kidder & wife, Nancy, in charge of local arrangements for the 16th Annual Meeting, Kauai, Hawaii. The Kidders own a home on the Island.

## LEGAL BRIEF The Marital Deduction

**By: Harold N. Walgren, M.D., J.D.**

There are two of them, and they are inter-related. The gift tax marital deduction allows an inter-spousal transfer of up to \$100,000 without paying a gift tax. There is, however, a deduction from the estate marital deduction of an amount equal to 50% of the gift.

The estate tax marital deduction allows a



Harold N. Walgren, M.D., D.J.

decendent to transfer to his spouse an amount equal to the greater of \$250,000 or 50% of the adjusted gross estate, free of federal estate taxes. This transferred amount would be reduced by 50% of any post-1976 gifts up to \$200,000. After \$200,000 of gifts to the spouse there is no further reduction of the estate tax marital.

The annual gift exclusion permits transfers of \$3,000 per person per year free of gift taxes. There is no effect on either marital deduction. A gift does not constitute income to the recipient for income tax purposes.

There is now a unified gift and estate tax credit of \$47,000 (as of 1 Jan 81). This allows either gifts or estate amounts to be passed of \$175,625 free of federal tax. The gift and estate tax rates are now the same.

If one transfers taxable gifts, deductions are made from the \$47,000 credit equal to the gift taxes that would have been due. Reducing the available credit by transferring taxable gifts also reduces the credit available for estate tax purposes. The credit is a unified one for transfers either by gift or by a decedent's estate.

Marital deductions are available for transfers by gift and from estates. It is often wise to balance spouses' estates when disproportionate. The marital deduction helps in this regard. The annual gift exclusion of \$3,000 operates outside of the marital deductions. Taxable gifts and estates first are allowed a unified tax credit of \$47,000 before federal taxes need to be paid.



# HEALTH CARE AT AN AIRPORT

By: Dorothy L. Bobbitt, R.N.

In 1975 Project No. 107, "Feasibility Study of Operating an Ambulatory Care Clinic at the Memphis International Airport," began with a small grant from the Memphis Regional Medical Program. Very careful attention was given to appropriate and quality equipment as a basis for continued service. The concept for this care has been in successful operation at the TVA steam plants for about fifty years.

My idea was to give more than the traditional industrial care, with a fine blend, to offer a wide range of assistance and feed into the present health care system.

From the outset this program has been a part of the University of Tennessee Center for the Health Sciences, (UTCHS) Department of Family Medicine. This department, along with support from community physicians and hospitals, provides a foundation for medical supervision.

At the end of the grant period the Health Station was made a line item in the airport budget, in a contractual agreement with the university. This arrangement gives a good base for the educational portion of the program and other supporting departments provide invaluable services.

The scope of the program is wide. A brief report of the emergency response can be given. I have prepared a large physician's bag for personal use in evaluation and care away from the Health Station, in a plane for example. This ability has proven to be helpful to the airlines. A "Doctor's Bag" of emergency equipment and medications, along with airway equipment is at the security dispatcher's desk ready for twenty-four hour response to a physician who might answer an emergency call. A trailer well equipped, and with back up supplies is on hand for a multi-casualty incident.

The objectives have not changed. The overall acceptance and practical application of the original ideas, especially of university support for such a service, have proven to be valid concepts.

This Health Station is practical, available, and cost effective. It practices preventive medicine, is involved with teaching, supporting, reporting, public relations and emergency planning. It is implementing programs and is putting into practice the therapeutic touch. I believe that nursing care as a component of health care can indeed make a difference. I am grateful for the opportunity to create a service that has been, and I believe will continue to be, beneficial in the future. I am proud to help the Memphis International Airport and UTCHS roll out the welcome mat to the ill or injured who happen to pass this way.

December 15, 1980

Dorothy L. Bobbitt, R.N.  
Health Station Memphis International Airport  
P.O. Box 30168  
Memphis, Tennessee 38130

Dear Ms. Bobbitt:

Thank you so much for your interesting outline of your service in Memphis. I feel that it would be of interest to our group and plan to publish it in the CAMA newsletter, and will send you a copy post publication.

Again on behalf of British Caledonian, and certainly myself, let me thank you for your professional assistance and personal kindness regarding Mr. Hampson. I shall look forward to seeing you sometime in the future.

Sincerely,

H.R. Conwell, M.D.  
2800 Lake Road  
Huntsville, Texas 77340

## HAVE YOU HEARD?

Dr. James M. Wallace has relinquished his former General and Anesthetic practice in Nova Scotia, and has joined the Department of Civil Aviation as a full time Civil Aviation officer for the Ontario region.

Dr. David S. Trump writes as follows: "I have recently been appointed the Mobilization Augmentee to the Commander of the Aeromedical Division, Major General John Ord, at Brooks AFB, San Antonio, and am a Colonel in the Air Force Reserve Medical Corps. In November I was Chairman of a two-day trauma symposium in Washington D.C. for the Association of Military Surgeons of the United States. And I recently spent a month 500 miles up the Amazon River in the jungle doing surgery with a medical project called "Esperansa".

CAMA member Dr. M. Young Stokes, III is President of the Texas Air Medics Association.

Dr. Olivio Amezcua, son of Past President, Luis A. Amezcua, is now in flight training, and plans to go with a Mexican Airline as both a pilot and aviation medical examiner.

Continued on page 7

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# IMPORTANT NEWS FOR A.M.E.'S

By: Hal Conwell, M.D.

As you were told in our first newsletter, this year will mark the beginning of major changes anticipated in the AME system. These changes range from a strong support by the Flying Farmers that the Third Class Physical be abolished altogether to those changes that will be recommended to Congress by the National Institute on Aging that could potentially result in a \$1000+ physical for a First Class medical certificate. Of more importance, there has been sharp and unwarranted criticism from this group of academics that could place the giving of these physicals only in major medical centers. This would lead to a disenfranchisement of practically all Senior AME's currently giving that examination. Now these recommendations are not hearsay, they are already in print and under committee deliberation. One of the most offensive inferences of this committee is that you, the AME, is so vulnerable to corruption that a professional pilot should not go to the same AME twice. Most freshmen medical students have enough clinical acumen to recognize that one of the most favorable tools that a physician has in evaluating the status of his patient (in this case the pilot) is a *continuity of observation*, and the mutual trust and respect that develops in a well-structured doctor-patient (pilot) relationship.

Of equal import, one of the most powerful Washington Lobbys in this country (AOPA), will be pressing for an increased time period between examinations of the Third Class Physical; and of more impact, to permit all licensed physicians, with or without FAA designation, to administer the Third Class Physical.

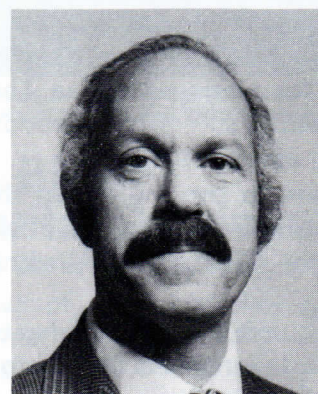
If you take your designation seriously, if you feel that your designation carries with it status with resultant responsibility to maintain that status, then I feel you should have sufficient interest to join a body that will represent your views and to motivate you to urge non-member AME's to join us. We then are a more effective voice for the expertise in Aviation Medicine represented by our organization.

If we fail to make our opinions known and to communicate our knowledge to those governmental agencies and individuals that determine policy and regulation, then we deserve whatever burdens are put upon us no matter how onerous they may be. We can become a social annual luncheon and debating society. All of you are invited and urged to attend our annual meeting in October and make your presence felt in what course aviation medicine, with regards to the AME, is going to follow in the foreseeable future.

# FIRST, SECOND or THIRD— IT'S STILL A PHYSICAL

By: William J. Morton, M.D.

REPRINTED FROM  
AVIATION TRAVEL & TIMES



William J. Morton, M.D.

Aviation Medical Examiner (AME in the trade!). What is it, who is it, how do you get to be one? Would you even want to be one? Well, let's not get carried away; I only have limited column space, but I'll do my best to tell you about AME's.

There are approximately 900,000 pilots in the U.S. (excluding military) and as every reader knows, each of us, depending upon the type of flying we do, will need a physical exam periodically. According to Part 61.43 of the Federal Aviation Regulations, a First Class physical is required every six months (usually for airline transport pilots). A Second Class physical (any commercial pilot or air traffic controller) is required every year, and a Third Class physical for most private pilots is good for two years.

The physical examination is almost exactly alike for all three classes (a different type of eye examination separates Class One and Two from Three), but the big difference is the degree of standards which separate each class. For example, the requirements for near vision for a First Class are more stringent than for a Second Class. The same goes for blood pressure, distant vision, etc. The FAA appoints a certain number of physicians (both medical and osteopathic) each year to perform physical examinations on the pilot population. Only those specifically appointed by the FAA may do the exams. To quote from the regs: "The AME *represents* the Administrator in the performance of delegated functions. *Examines* applicants to obtain information essential to determining their qualifications for medical certification. *Decides* whether applicants meet the pertinent medical standards prescribed in Federal Aviation Regulations, Part 67. *Issues* or *Denies* airman medical certificates."

This is pretty heady stuff for your local Doc. Each AME has some special reason for doing these physicals and also has taken extra time to earn the regulations from the FAA. First Class exams can only be performed by physicians who have been AME's for 5 years and must be again specifically appointed by



the FAA to do these exams. The responsibility in examining an Airline Transport Pilot is somewhat greater than for that of the Cessna 150 pilot. Each AME is required to attend at least one seminar (especially prepared by the FAA) every five years. Most of my AME friends go more frequently than that, but at least the requirement is every five years.

Most AME's are not pilots (a severe handicap in my opinion) but then again a physical is a physical, and the idea of a physician-pilot doing your FAA physical, while nice, is not *that* necessary. In my area (Atlanta) about 35% of the AME's are pilots and the rest are just plain ordinary physicians. There is no question that the physician-pilot has a better feel for the exam and can answer any questions from a slightly better advantage point, but the non-pilot AME also does a darn good job.

To find an AME for your physical, get the *Directory of Aviation Medical Examiners*, compiled by the FAA (available at most FBO's, the airport manager's office, or if you're in the "big city," call the local Federal Air Surgeon's office.) Word of mouth is another reliable way to find a good AME. Of course, we all know there are AME's and there are AME's. You pay your money and you take your choice. But, remember that old adage, "Beware of AME's bearing gifts."

Rather than go to one of those physical exam mills that roll out endless FAA physicals every day, pick an AME with whom you can establish some rapport and let him be your aviation physician. It will pay off in the long run.

Practically speaking, the actual physical exam consists of taking the vital signs (blood pressure, pulse, respiration); a pretty good eye examination with an ear, nose and throat look-see. Listening to the heart and lungs is next, feel the abdomen, check for a hernia, examine the prostate in men over forty (that's the urologist in me coming out), do a little running in place, and also check the urine for sugar, protein and abnormal microscopic cells. That is not your basic \$250.00 physical, but it is good enough to give the AME a basis for evaluation. If any of this is abnormal, it will be picked up somewhere in the exam and then greater concentration can be given to the appropriate problem the history given by the pilot-patient is of utmost importance. We all know that if the patient doesn't give the doctor an accurate history (even an insulin dependent diabetic could lie to the AME and the diabetes could go undetected), he can be passed quite innocently. Of course, lying (overtly or by omission) is a no-no and can be detrimental to your flying career (and your pocketbook).

How much should you expect to pay for your flight physical? Well, that is a difficult question and the answer is even more difficult, because it varies so. I personally charge \$35 in my office for all FAA physical exams. In calling around Atlanta, I found the fees were usually in that range. One fact I did find (which sort of annoyed me) was that most AME's charge more for a First Class than a Third. Why, I don't know. The physicals are almost exactly alike.

It is sort of like paying \$2.50 for an overnight tie-down for your single, but if you happen to be rich enough to fly a twin, you get hit for a \$5.00 fee. I *know* why the difference in price, but I could never get anyone to logically explain it and it sort of irks me to get ripped-off. (I fly a single, by the way!)

Be that as it may, call around to a few of the AME's offices and get a feel for the going rate. Medicine, for good or bad, is a commodity in this country and has a price tag on it. Don't let the bargain price attract you. Most physicians put a fair value on their time and services, but also the most expensive does not necessarily mean the best.

The following is a list of the conditions which, because of an "established medical history" or "clinical diagnosis," a medical certificate will be denied, according to Part 67 of the FAR's: "A personality disorder that is severe enough to have repeatedly manifested itself by overt acts; a psychosis, alcoholism; drug dependence; epilepsy; disturbance of consciousness without satisfactory explanation of cause; myocardial infarction; angina pectoris or other evidence of coronary disease; diabetes mellitus that requires insulin or any other hypoglycemic drug for control."

If you do happen to have your medical certificate denied, there are several options open to you. Though not necessarily listed in order, your options include an appeal, review, evaluation, reconsideration hearing, and appellate review that pass from the Regional Flight Surgeon, to the Aeromedical Certification Branch, Federal Air Surgeon (Medical Review Board), FAA Administrator (Exemption cases), National Transportation Safety Board Examiner, Full National Transportation Safety Board, and the U.S. Court of Appeals.

Well, there you have it. All you need to know about your friendly AME in one easy lesson. Not really, but this is a brief introduction to what every pilot should know about his medical examiner. I encourage you to establish some relationship with him, find out about his background, talk flying (particularly if he is a pilot), and above all, be honest with him. I guarantee you'll both be better off for it.

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Have you heard? (Continued from page 5)

Dr. Ibrahim S. Ayoub has been awarded the Order of the British Empire, granted by the Queen for services rendered.

Dr. Zuhair Malhas, who trained at Northwestern University's School of Medicine, became Jordan's first specialist in internal medicine. Elected President of Jordan's Society of Internal Medicine, he was also awarded a fellowship of the American College of Physicians.

President-elect Dr. Roy M. Stewart was a speaker at the 28th International Congress of Aviation and Space Medicine, held in Montreal.



# WELCOME ABOARD

**We are happy to welcome the following new members into the fellowship of CAMA:**

R. Douglas Bransford  
Spring, Texas

Capt. Harold E. Cameron  
Huntsville, Texas

Dr. J.E. Charles-Jones  
Chester, England

Yvonne S. Crosby, R.N.  
Elm Grove, Wisconsin

David T. Eith, M.D.  
Honolulu, Hawaii

Joseph W. Elbert, D.O.  
Petersburg, Indiana

Dr. D.A. Hanton  
Manitoba, Canada

Dr. Gordon Hickish  
Hampshire, England

Warren E. Hinton, M.D.  
Huntsville, Texas

Sami Khurma, M.D.  
Amman, Jordan

Junaid N. Mahmoud, M.D.  
Amman, Jordan

Zuheir Malhas, M.D.  
Amman, Jordan

Dr. S. Minocha  
Audlin, England

Gerard Naud, M.D.  
Quebec, Canada

Harold Peterson, M.D.  
San Diego, California

Gilbert Rubin, M.D.  
Winchester, Oregon

James W. Short, M.D.  
McAllen, Texas

Dr. W. John Street  
Bedford, England

Mark G. Swedenburg, M.D.  
APO, San Francisco, California

Ronald Tegtmeier, M.D.  
Arvada, Colorado

Jack L. Ventling, Ph.D.  
Poland, Ohio

Here is a breakdown of our membership outside the United States:

Canada	62	Japan	1
Mexico	7	Jordan	7
Afghanistan	1	Kenya	2
Belgium	1	Korea	1
Argentina	1	Kuwait	1
Australia	1	Lebanon	1
Bahamas	1	Libya	1
Chile	1	Malta	1
Costa Rica	1	Netherlands	1
Cyprus	1	New Guinea	1
Denmark	1	Republic of Panama	1
Ecuador	1	Saudi Arabia	3
England	13	South Africa	1
Ethiopia	1	Spain	3
France	2	Republic of S. Africa	1
Germany	4	Sri Lanka	1
Ghana	7	Suriname S.A.	1
Iceland	1	Switzerland	2
Iran	1	United Arab Emirates	1
Iraq	1	West Indies	4
Italy	1		

Chairman of the Nominating Committee, Harold N. Walgren, wishes to hear from members who would like to serve on the Board of Directors. CAMA by-laws provide for the retirement of several Trustees after a three year period, and these vacant spots must be filled with new faces. So write to Hal if interested.

## EDITORIAL STAFF

### EDITOR

Harold N. Walgren, M.D., D.J.

### ASSISTANT EDITOR & PRODUCTION MANAGER

Albert Carriere

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